THERAPEUTIC COURT PARTICIPANT: PLEASE ATTACH YOUR MEDICAL DISCHARGE SUMMARY TO THIS FORM

Clark County District Court
Therapeutic Specialty Courts
1200 Franklin Street
PO Box 5000
Vancouver, WA 98666-5000
Tel. #(564) 397-4166

To Prescribing Physician / Psychiatrist / Dentist / Urgent Care / Other Health Care Prescriber:

Please note that your patient or prospective patient is a participant in Clark County Mental Health Court.

We hope that you or your representative will sign this letter and provide our program with a comprehensive list of medications being prescribed to our participant and acknowledge that the participant has discussed their substance use history and/or mental health history with you. If a current participant is prescribed any ***potentially*** addictive medication, we require that they have an **honest discussion** of their substance use/addiction history with you, leaving it to your discretion whether the medication to be prescribed or other alternative non-narcotic medication should be considered. If you have any questions, please contact Erin Welch, Probation Services Case Manager at (564) 397-4166 or erin.welch@clark.wa.gov.

Print name of Participant:

Name of Facility: _____ Date: _____ Time seen: _____ Time out:_____

REASON FOR VISIT: _____

PLEASE LIST MEDICATION(s) USED DURING THIS VISIT AND/OR PRESCRIBED TODAY:

Name of Rx: _____Quantity:_____Dosage: _____ Refill: _____Other: _____

Name of Rx: _____Quantity:_____Dosage: _____ Refill: _____Other: _____

Name of Rx: _____Quantity:_____Dosage: _____ Refill: _____Other: _____

Other general comments: _____

Prescriber to initial here _____ if the patient has disclosed to you any pertinent information: (i.e. pregnancy, if they are on Medically Assisted Treatment, or if the patient has informed you of any other medications that will affect what you are prescribing today).
What was disclosed: _____

_____ _____
Prescriber signature *Date* *Participant signature* *Date*

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION:
I, (Name of defendant) _____, authorizes all Clark County District Court Therapeutic Specialty Court program members and (Prescriber)_____ to communicate with and disclose to one another the following information:

(Defendant's initials) _____ my diagnosis, prescription, testing results, information related to client physical or mental health condition.

The purpose of the disclosure is to coordinate and integrate medical and behavioral health treatment services. I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically at the conclusion of Drug Court Participation:

Dated: _____ Signature of Patient _____

PROHIBITION ON REDISCLOSURE: This notice accompanies a disclosure of information concerning a client in mental health and/or alcohol/drug treatment, made to you with the consent of the client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2 prohibits unauthorized disclosure of these records.). The federal rules prohibit you from making any further disclosure of this information unless further disclosure if expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any patient. [Updated 03/2022]